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Office of Administrative Law Judges
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Issue Date: 31 October 2006

Case No.: 2004-BLA-5734

In the Matter of:

G.B., for the Estate of
J.B., Deceased,
Claimant

v.

ISLAND CREEK COAL COMPANY,
Employer

CONSOL ENERGY, INC.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Stephen A. Sanders, Esq.
Prestonsburg, Kentucky
For the Claimant

Eric R. Collis, Esq.
Louisville, Kentucky
For White Ash/Employers Reinsurance

Natalee Gilmore, Esq.
Lexington, Kentucky
For Island Creek/Consol Energy

Thomas A. Grooms, Esq.
Nashville, Tennessee
For the Director, OWCP

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS IN THE LIVING MINER'S CLAIM AND AWARDING BENEFITS IN THE SURVIVOR'S CLAIM

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901, *et seq*. (the "Act"). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2001). This claim involves a combined living miner's and survivor's claim.

G.B., represented by counsel, appeared at the formal hearing held June 6, 2006, in Prestonsburg, Kentucky. I afforded both parties the opportunity to offer testimony, question witnesses, and introduce evidence. Thereafter, I closed the record. I based the following Findings of Fact and Conclusions of Law upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. Although perhaps not specifically mentioned in this Decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. Although the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformity with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this Decision exclusively pertain to that Title. References to DX, EX, and CX refer to the exhibits of the Director, Employer, and Claimant, respectively.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

J.B. ("the Miner") filed his first application for black lung benefits on June 14, 1977. His claim was denied by the District Director on May 7, 1980. He did not appeal the decision. The Miner then filed a subsequent claim in 1997. This claim was also denied by the District Director on May 27, 1997. The Miner did not appeal this decision and the denial became final. Thereafter, the Miner filed the current subsequent claim for benefits on December 1, 1998. The District Director subsequently granted benefits. The Employer appealed the decision and the claim was transferred to the Office of Administrative Law Judges on August 17, 1999. The claim was then assigned to me. The Miner requested a continuance at the March 2, 2000, hearing so that he could obtain counsel. The continuance was granted. The claim was then reassigned to Judge Phalen. Another hearing was held on January 17, 2001. Judge Phalen issued an order of remand for the development of evidence on the issue of responsible operator. The claim was then transferred back to the Office of Administrative Law Judges on August 15, 2001. On February 5, 2002, Judge Roketenetz issued another order of remand for development of evidence on the issue of responsible operator. The claim was then transferred back to the Office of Administrative Law Judges on February 9, 2005. Another hearing was held on June 6, 2006. Thereafter, I issued an Order dismissing White Ash Mining Corporation and Employers Reinsurance Corporation as parties to the action. I found that Island Creek Mining Company was the properly designated responsible operator in the Miner's claim.

The Miner died on November 13, 2001. G.B. ("the Claimant") filed her claim for survivor benefits on November 19, 2001. The District Director awarded her benefits on May 9, 2003. The Director named Island Creek Mining Company as the responsible operator in her claim. However, on November 4, 2003, the Director issued a revised order awarding benefits identifying White Ash Mining Corporation as the responsible operator. White Ash Mining Corporation requested a formal hearing and the claim was then transferred to the Office of Administrative Law Judges. After the formal hearing, I issued an Order dismissing White Ash Mining Corporation as the responsible operator. Therefore, Claimant's award of benefits is no longer contested and the decision of the District Director awarding benefits is final. Accordingly, the Trust Fund is liable for the Claimant's award of benefits in her survivor's claim.

Factual Background

The Miner was born on April 13, 1927. (DX 1). He had an eighth-grade education. (DX 1). He was married to the Claimant. (DX 1). He worked the majority of his career in underground coal mines. (Tr. 38). The Claimant testified that the Miner would return home from work covered in coal dust. (Tr. 39). He left the mines on April 22, 1977, due to a stroke. (DX 1; Tr. 38). The Claimant stated that the Miner suffered from coughing, sputum production and shortness of breath. (Tr. 39-40). The Miner had trouble climbing steps due to his breathing condition. (Tr. 40). Between 1977 and his death, the Miner was treated at VA Medical Center in Huntington. (Tr. 41). Dr. Mavi was his treating physician. (Tr. 41). The Miner also had a history of a heart attack, heart surgery, and lung cancer. The Claimant agreed that the Miner smoked but stated that he quit around five or six years prior to his death. (Tr. 42). However, she stated that while at work, the Miner was not allowed to smoke. (Tr. 44). Therefore, during the eight hours a day he was at work, he did not smoke. (Tr. 44). The treatment records and medical reports include varying smoking histories. The evidence is contradictory and I am unable to make a smoking determination at this time.

Contested Issues in the Miner's Claim

The parties contest the following issues regarding this claim:

1. Whether the Miner's claim was timely filed;

2. The length of the Miner's coal mine employment;

3. Whether Island Creek Coal Company is the properly designated responsible operator;[1]

4. Whether the Miner had pneumoconiosis as defined by the Act and the regulations;

[1] An Order was issued on October 5, 2006, finding Island Creek the properly designated responsible operator in the Miner's claim.

5. Whether the Miner's pneumoconiosis, if present, arose out of coal mine employment;

6. Whether the Miner was totally disabled;

7. Whether the Miner's total disability, if present, is due to pneumoconiosis; and,

8. Whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309(c), (d).

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. The Miner's length of coal mine employment is an uncontested issue. The District Director made a finding of 15+ years in coal mine employment. The documentary evidence includes the Claimant's Social Security earnings report and an employment questionnaire. The Employer stipulated to 15 years of coal mine employment at the hearing. (Tr. 36). The evidence of record supports a finding of 15 years in coal mine employment. Accordingly, based upon all the evidence in the record, I find that the Miner was a coal miner, as that term is defined by the Act and regulations, for 15 years. He last worked in the Nation's coal mines in 1977.

Dependency

The Miner alleged one dependent for the purposes of benefit augmentation, namely his wife, G.B. They married on July 15, 1950. The record includes their marriage certificate and the Claimant testified to her dependency. Accordingly, I find that the evidence of record supports a finding that the Miner had one dependent for the purposes of benefit augmentation.

Timeliness

Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. The Employer must rebut this presumption. The Employer has neither presented evidence nor pointed to any evidence establishing that this claim was not timely filed. In the Employer's brief it never presented an argument on the issue of timeliness. To overcome the presumption that a claim is untimely, the Employer must prove that the record includes a well-reasoned and well-documented opinion finding the miner totally disabled due to pneumoconiosis. *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.). Furthermore, the Employer must prove that this opinion was actually communicated to the Miner. There is no evidence in the record indicating that the Miner was ever informed that he was totally disabled due to pneumoconiosis by a physician presenting a well-reasoned and well-documented opinion prior to three years of filing his claim. Therefore, the Employer has failed to meet its burden, and I find that this claim was timely filed.

Medical Evidence

The Miner's claim was filed prior to the 2001 amendments which placed limitations on the amount of evidence presented. However, since this is a subsequent claim, only evidence submitted after May 27, 1997, the date of the prior denial, will be considered unless a material change in physical condition is proven. 20 C.F.R. § 725.309(d). I will also only summarize the evidence relating to whether the Miner suffered from pneumoconiosis. If the Claimant proves pneumoconiosis, I will then discuss the other medical evidence.

X-ray Reports[2]

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
DX 9	11/30/98	Sargent, M.D. B reader/BCR	Quality reading only Unreadable
DX 7	01/13/99	Maan Younes, M.D. B reader	2/1
DX 9	01/13/99	Sargent, M.D. B reader/BCR	0/1
DX 10	01/13/99	Peter Barrett, M.D. B reader BCR	1/1
DX 31	01/13/99	A. Dahhan, M.D. B reader	No abnormalities consistent with pneumoconiosis
DX 57	01/13/99	William Scott, M.D. B reader/BCR	No abnormalities consistent with pneumoconiosis
DX 57	01/13/99	Paul Wheeler, M.D. B reader/BCR	No abnormalities consistent with pneumoconiosis
DX 32	7/17/99	A. Dahhan, M.D. B reader	No abnormalities consistent with pneumoconiosis
DX 57	7/17/99	Jerome Wiot, M.D. B reader/BCR	No abnormalities consistent with pneumoconiosis
DX 59	7/17/99	Gregory Fino, M.D. B reader	Completely negative
DX 60	7/17/99	W.K.C. Morgan, M.D. B reader	No evidence of pneumoconiosis
DX 71, 89	7/17/99	Enrico Cappiello, M.D. B reader/BCR	1/1
DX 71, 89	7/17/99	Afzal Ahmed, M.D. B reader/BCR	1/1

[2] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. § 718.102(a) and (b). It is not utilized to determine whether the Miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the Miner may be presumed to be totally disabled due to the disease.

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
DX 98	7/17/99	Peter Barrett, M.D. B reader/BCR	This reading is actually dated 6/12/00; however, the reading has a post-it note attached stating that the reading should have been dated 7/17/99. I have no way of knowing whether the reading was actually misdated or not. There is nothing from the actual physician stating that it was misdated. Therefore, I will have to treat it as a reading of the 6/12/00 film.
DX 59	12/18/99	Gregory Fino, M.D. B reader	Completely negative
DX 64	12/18/99	Jerome F. Wiot[3] B reader/BCR	No abnormalities consistent with pneumoconiosis
DX 71, 89	12/18/99	Enrico Cappiello, M.D. B reader/BCR	1/1
DX 76, 89	12/18/99	Afzal Ahmed, M.D. B reader/BCR	1/1
DX 98	12/18/99	Peter Barrett, M.D. B reader/BCR	This reading is actually dated 6/12/00; however, the reading has a post-it note attached stating that the reading should have been dated 12/17/99. I have no way of knowing whether the reading was actually misdated or not.

[3] Dr. Wiot also discussed his opinion in his July 20, 2000, and November 16, 2000, deposition testimony. (DX 72; 79). Dr. Wiot discussed his qualifications and experience in diagnosing pneumoconiosis. He further opined that the Miner did not suffer from pneumoconiosis. He stated that the December 18, 1999, film was underexposed, which gives the appearance that there is more disease present then actually really exists. Dr. Wiot believed the film showed no evidence of pneumoconiosis. He indicated that there were pleural and bullous changes present which are not associated with coal dust exposure. He related the conditions to coronary artery disease and emphysema. (DX 72; 79).

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
			(Cont.) There is nothing from the actual physician stating that it was misdated. Therefore, I will have to treat it as a reading of the 6/12/00 film.
DX 65, 89	05/31/00	Manu Patel, M.D. B reader/BCR	1/1
DX 73	05/31/00	William Scott, M.D. B reader/BCR	No abnormalities consistent with pneumoconiosis
DX 73	05/31/00	Paul Wheeler, M.D. B reader/BCR	No abnormalities consistent with pneumoconiosis
DX 74	05/31/00	Jerome Wiot, M.D. B reader/BCR	No abnormalities consistent with pneumoconiosis
DX 74	05/31/00	Harold Spitz, M.D. BCR[4]	No abnormalities consistent with pneumoconiosis
DX 78	05/31/00	Thomas Miller, M.D. B reader/BCR	1/2
DX 98	05/31/00	Peter Barrett, M.D. B reader/BCR	No abnormalities consistent with pneumoconiosis
DX 73	06/12/00	William Scott, M.D. B reader/BCR	No abnormalities consistent with pneumoconiosis
DX 73	06/12/00	Paul Wheeler, M.D. B reader/BCR	No abnormalities consistent with pneumoconiosis
DX 74	06/12/00	Harold Spitz, M.D. BCR	No abnormalities consistent with pneumoconiosis
DX 74	06/12/00	Jerome Wiot, M.D. B reader/BCR	No abnormalities consistent with pneumoconiosis
DX 78	06/12/00	Thomas Miller, M.D. B reader/BCR	1/2
DX 98	06/12/00	Peter Barrett, M.D. B reader/BCR	No abnormalities consistent with pneumoconiosis

[4] Dr. Spitz' CV indicates that he was only recertified as a B reader until 1997. His CV does not state that he was recertified after that date and, therefore, I must treat him as only a B-certified Radiologist.

Narrative Medical Evidence in the Miner's Claim

Maan Younes, M.D., Board-certified in Internal Medicine and Pulmonary Diseases, provided the Miner with a department-sponsored pulmonary examination on January 13, 1999. (DX 7). Dr. Younes recorded that the Miner worked 27 years in coal mine employment until 1977. The Miner had a history of wheezing attacks, chronic bronchitis, arthritis, heart disease, breast cancer, high blood pressure, stroke, congestive heart failure and heart attacks. Dr. Younes noted that the Miner started smoking half a pack of cigarettes per day when he was 13 years old until four years prior to the examination. The Miner's symptoms included daily sputum production, wheezing, dyspnea, cough, chest pain upon exertion, orthopnea, ankle edema, and paroxysmal nocturnal dyspnea. Dr. Younes performed a physical examination, chest x-ray, pulmonary function tests, and arterial blood gas studies. Upon examination, he noted decreased breath sounds at auscultation. (DX 7).

Dr. Younes diagnosed the Miner with pneumoconiosis based on the chest x-ray evidence and history of coal dust exposure; chronic obstructive pulmonary disease related to congestive heart failure based upon the pulmonary function testing; chronic bronchitis related to cigarette smoking based upon the Miner's history of cough and sputum production; congestive heart failure based upon his coronary artery disease; and, coronary artery disease based upon his risk factors of family history and smoking. (DX 7). He also opined that the Miner suffered from a moderate obstructive impairment related to smoking based upon the pulmonary function testing. He stated that the Miner was totally disabled but he related the condition to the Miner's hypoxemia caused by his congestive heart failure. (DX 7).

Jasbir S. Mavi, M.D., the Miner's treating physician, submitted a medical opinion on the Miner's medical condition. (DX 28; CX 2). Dr. Mavi treated the Miner between August 1999 and his death on November 13, 2001. He stated that he had "first-hand knowledge of [the Miner's] medical condition, subjective complaints and progression of his medical condition." Dr. Mavi recorded a 20 to 25-year coal mine employment history and found that the Miner smoked during his adult life but quit in 1995. He did not state the rate the Miner smoked. Dr. Mavi stated that throughout his treatment the Miner's breathing status continued to worsen. The Miner was placed on oxygen in 2000. Dr. Mavi treated the Miner for chronic obstructive pulmonary disease and diffuse interstitial lung disease. Dr. Mavi related the Miner's conditions to coal dust exposure. He based his opinion on the Miner's chest x-ray evidence, the pulmonary function testing, and the progressive nature of his condition. Dr. Mavi stated that after the Miner quit smoking in 1995 his breathing condition continued to get worse. He noted that "when a smoker quits smoking, he/she shows some symptomatic improvement though the lung damage is not reversed." (DX 28).

Abdulkader Dahhan, M.D., Board-certified in Internal Medicine and Pulmonary Diseases, examined Claimant on July 17, 1999. (DX 32). He recorded an employment history of 22 years in coal mine employment and a 27 pack year smoking history. Upon examination, Dr. Dahhan found at auscultation bilateral scattered expiratory wheezes with no crepitations or pleural rubs. There was no clubbing or edema. He also conducted a chest x-ray and pulmonary function testing. Dr. Dahhan found no evidence of pneumoconiosis on the Miner's chest x-ray. The pulmonary function testing was invalid due to poor effort. Dr. Dahhan also reviewed some of the other medical evidence in the record. Based on his examination of the Miner and his

review of the records, Dr. Dahhan found no evidence of pneumoconiosis or any other condition related to coal dust exposure. He also based his opinion on the findings of an obstructive defect along with a clear chest x-ray and normal blood gas studies. Dr. Dahhan further opined that the Miner was not totally disabled from his regular coal mine employment from a respiratory standpoint based upon the chest x-ray, pulmonary function tests, and the arterial blood gas studies. He related the Miner's chronic bronchitis to smoking and found that he suffers from coronary artery disease. (DX 32).

Dr. Dahhan submitted a supplemental consultative report on May 1, 2000. (DX 56; EX 8). In the report he examined his prior findings and some of the other medical evidence. Dr. Dahhan noted again that the Miner worked 22 years in coal mine employment and smoked half a pack of cigarettes per day between the ages of 14 and 68. He noted that the Miner had a "history of cough, sputum production, wheezing, shortness of breath, coronary artery disease, hypertension, fluid retention and hyperlipidemia." Dr. Dahhan also found a history of right mastectomy for cancer. He stated that he reviewed the medical records and found no evidence of pneumoconiosis. However, Dr. Dahhan noted that his prior examination of the Miner's chest revealed bilateral expiratory wheezes. He diagnosed the Miner with an obstructive defect, but no pulmonary disability related to coal dust exposure. Dr. Dahhan never actually explained in this report the basis of his opinions. He merely stated that he relied upon his prior report and the medical records. (DX 56; EX 8).

Dr. Dahhan provided another supplemental report dated December 4, 2000. (DX 80). He continued to find the evidence insufficient to diagnose pneumoconiosis. He considered the Miner totally disabled based on the arterial blood gas studies; however, he related the condition to the Miner's coronary artery disease. (DX 80).

Ben V. Branscomb, M.D., provided a consultative report on May 30, 2000. (DX 60). Dr. Branscomb previously issued a report dated October 6, 1999, where he found no evidence of pneumoconiosis or a respiratory impairment related to coal dust exposure. However, he found the Miner totally disabled due to his severe coronary artery disease, chronic congestive heart failure, prior stroke, and pneumonias. Dr. Branscomb did not state the coal mine employment history that he took into consideration. He found that the Miner was very obese. Dr. Branscomb summarized the evidence that he took into consideration in this supplemental report. He continued to find no evidence of pneumoconiosis based on the chest x-ray and CT scan evidence or a respiratory impairment. He opined that the Miner was able to return to his regular coal mine employment based strictly on a pulmonary perspective; however, he failed to explain the basis of this finding. (DX 60).

Dr. Branscomb submitted a supplemental consultative report on December 7, 2000. (DX 80). He continued to opine that the Miner did not suffer from pneumoconiosis. However, he now agrees that the Miner was totally disabled based on the arterial blood gas evidence. He related the Miner's condition to an embolism in the Miner's lower lobe as illustrated on the chest x-ray evidence. (DX 80).

W.K.C. Morgan, M.D., submitted a consultative report dated June 3, 2000. (DX 60). He reviewed the medical records between 1991 and 1999 in forming his opinions. He took into consideration the July 18, 1997, July 18, 1998, May 6, 1998, and March 16, 1998, chest x-ray readings of other physicians. Dr. Morgan also reviewed the July 17, 1999, chest x-ray film.

Next he examined a CT scan reading. He then examined some of the Miner's treatment records. He found no evidence of pneumoconiosis based on the records he reviewed which made no mention of pneumoconiosis. However, he found that the Miner was slightly impaired due to an airway obstruction. He related the condition to smoking but did not state a basis for the opinion. Dr. Morgan found the Miner totally disabled due to his past stroke and heart disease. (DX 60).

Next, Dr. Morgan supplied the Employer with a supplemental report written December 6, 2000. (DX 80). He has submitted additional medical data taken since his prior report. He continued to opine that the Miner did not suffer from pneumoconiosis. He continued to state that the newly submitted chest x-ray readings did not support a finding of pneumoconiosis despite the fact that the new evidence included four positive readings. Dr. Morgan related the Miner's hypoxemia to obesity, but he did not discuss why coal dust exposure was not a factor. He also gave little weight to Dr. Patel's positive chest x-ray reading stating that Dr. Patel always reads a black lung claimant's film as positive. Dr. Morgan attributed the Miner's reduced diffusing capacity to smoking stating that "nonsmoking coal miners' have a normal diffusing capacity, whether or not they have simple CWP." He also relates the Miner's reduced left ventricular function to heart disease stating that it is known to cause restrictive impairment. Furthermore, Dr. Morgan states that it is "generally recognized that CWP does not progress after exposure ceases," a statement that is clearly against the heart of the regulations. Dr. Morgan related the Miner's decline to merely his cardiac condition. Overall, he diagnosed the Miner with a mild respiratory impairment due to smoking and coronary artery disease. (DX 80).

Dr. Morgan reiterated the findings in his reports in his January 10, 2001, deposition testimony. (DX 85). He further opined that the Miner did not suffer from pneumoconiosis or any other coal dust-related condition. He related his respiratory impairment solely to smoking and coronary artery disease. He based his opinion on the objective testing within the record. (DX 85).

He provided another supplemental report dated December 29, 2005. (EX 2). Dr. Morgan continued to opine that the Miner does not suffer from pneumoconiosis based upon the chest x-rays and pulmonary function tests. He diagnosed a mild airway obstruction related to smoking. Dr. Morgan also found a restrictive impairment related to the Miner's cardiac failure. He noted only a mild respiratory impairment related to his cardiac condition and smoking. He also found the Miner disabled due to a stroke. (EX 2).

Gregory J. Fino, M.D., Board-certified in Internal Medicine and Pulmonary Diseases, submitted a report dated February 3, 2000. (DX 64). Dr. Fino examined the medical evidence in the record and his findings in his 1999 report. He summarized the evidence he reviewed. Dr. Fino opined that the Miner did not suffer from pneumoconiosis based upon his review of the chest x-ray readings, the spirometry data showing no obstruction, restriction or ventilatory impairment, the arterial blood gas testing, and the Miner's lung volumes. He found that the Miner had normal lung volumes. Dr. Fino determined that the Miner suffered from resting hypoxemia related to obesity. He found that the Miner did not suffer from a respiratory impairment. He further stated that even though he was only a reviewing physician, he is in just as good a position as a treating or examining physician to form an opinion on the Miner's condition. Dr. Fino also cited numerous research articles to support his opinions. (DX 64).

Dr. Fino provided a supplemental report on June 14, 2000. (DX 61). Dr. Fino summarized all the additional evidence that he reviewed. Dr. Fino opined that the Miner did not suffer from any pulmonary condition related to coal dust exposure. He based his opinion on the chest x-rays and clinical data that he reviewed. Dr. Fino stated that coronary artery disease was the Miner's major medical condition. He stated that "there is insufficient evidence to make a diagnosis of any disability arising out of his pulmonary system, or specifically a pulmonary disability due to coal dust inhalation." However, Dr. Fino opined that that the Miner would have been disabled even if he had never worked in coal mine employment. (DX 61).

The record also includes another supplemental report from Dr. Fino written December 15, 2000. (DX 80). Dr. Fino reviewed the newly submitted evidence in the record since his last report. He continued to opine that the Miner suffered from no occupational lung disease and was not disabled from a pulmonary standpoint. He also continued to relate the Miner's obstructive defect to smoking based on the pulmonary function testing. Dr. Fino related the changes illustrated by the arterial blood gas study to the Miner's heart condition and emphysema related to smoking. He opined that coal dust exposure had no effect on the test results based upon the fact that when the Miner left the mines in 1977 he had a normal lung function. (DX 80).

In addition, the record includes another supplement report by Dr. Fino dated January 18, 2006. (EX 6). Dr. Fino reiterated the findings in his prior reports and further stated that he opined that the Miner does not suffer from pneumoconiosis or any other condition related to coal dust exposure. He diagnosed the Miner with chronic obstructive pulmonary disease due to smoking based upon the time the Miner developed an obstruction and the pulmonary function testing. He cited numerous medical research studies to support his opinion. Dr. Fino determined that he no longer attributes the Miner's hypoxemia to merely heart failure. He now stated that emphysema also contributed to the condition. (EX 6).

James R. Castle, M.D., Board-certified in Internal Medicine and Pulmonary Diseases, submitted a consultative medical report on June 29, 2000. (DX 62). Dr. Castle noted 30 years in coal mine employment as a loader operator, roof bolter, cutting machine operator, and a joy loader. He also noted a 30 pack-year smoking history. Dr. Castle examined a number of medical reports, chest x-ray readings, pulmonary function tests, and arterial blood gas studies. He found that the Miner had three pulmonary risk factors, including coal dust exposure, smoking, and coronary artery disease, all of which can cause the pulmonary symptoms that the Miner experienced. However, he opined that the Miner did not suffer from pneumoconiosis based on the chest x-rays, CT scans, pulmonary function testing, arterial blood gas studies, and medical histories. Dr. Castle stated that the chest x-rays and CT scans revealed "some areas of increased interstitial markings of an irregular type in the lower lung zones which are not associated with pneumoconiosis." Also some pleural calcification was found. Dr. Castle opined that these findings are not normally associated with pneumoconiosis. He stated that "pneumoconiosis causes the presence of small, round, regular opacities in the upper lung zones. It does not cause the presence of irregular opacities in the bottom portions of the lungs." Furthermore, Dr. Castle found no evidence of rales, crackles, or crepitations which are expected in someone who suffers from pneumoconiosis. However, decreased breath sounds were noted, which is consistent with the Miner's history of smoking. He also noted the presence of emphysema. Dr. Castle further opined that the Miner did not suffer from a respiratory disability based on the pulmonary function and arterial blood gas studies and he could return to his regular

coal mine employment from a pulmonary perspective. He diagnosed the Miner with a minor degree of hypoxemia related to smoking. (DX 62).

Dr. Castle reiterated his findings and opinions in his July 11, 2000, deposition testimony. (DX 67; 69). In addition to the records reviewed for his initial report, Dr. Castle reviewed the medical report of Dr. Rasmussen in preparation for his deposition. Dr. Castle testified that he had more information available to him to form an opinion on the Miner's condition then any examining physician. He agreed that the Miner's smoking and coal dust exposure histories were sufficient to cause a respiratory condition. However, he found that the Miner's history of coronary artery disease was the most significant in forming his opinion. He stated that this condition was not related to coal dust exposure. Dr. Castle testified that the pulmonary function testing conducted by Dr. Rasmussen revealed a mild airway obstruction which he related to smoking. He did not relate the condition to coal dust exposure because the tests did not reveal a mixed irreversible obstructive and restrictive ventilatory impairment. He found no restrictive impairment at all. Dr. Castle acknowledged that the Miner's arterial blood gas studies revealed an abnormality but he related the condition to the Miner's cardiac condition based upon the chest x-ray and electrocardiogram evidence also taken at the time. Dr. Castle then explained that the positive chest x-ray readings do not mean that the Miner suffered from pneumoconiosis but instead he related the readings to the Miner's chronic congestive heart failure which can cause interstitial irregular opacities in the lower lobes. Dr. Castle opined that the Miner was totally and permanently disabled due to his coronary artery disease, congestive heart failure, and cardiomyopathy, but not coal dust exposure. He based this opinion on the Miner's physical exams, history, chest x-rays, clinical testing, and cardiac evaluations. (DX 67; 69).

Dr. Castle wrote a supplemental consultative report on December 20, 2000. (DX 82). After summarizing the additional evidence that he reviewed, he reiterated his findings in his prior report. He continued to believe that the Miner did not suffer from pneumoconiosis or any other coal dust-related condition. He based his opinion on the chest x-ray evidence. However, based on the pulmonary ventilatory studies, he opined that the Miner suffered from a degree of emphysema which caused the abnormalities shown on the arterial blood gas studies. The only change he made to his opinion was that he now believes the Miner was totally disabled based on the arterial blood gas studies. He related the impairment to the Miner's coronary artery disease and smoking-induced chronic obstructive pulmonary disease. (DX 82).

The record also includes another supplemental report from Dr. Castle dated January 19, 2006. (EX 4). He fully summarized all the evidence that he took into consideration. He continued to opine that the Miner did not suffer from pneumoconiosis or any other coal dust-related condition. He based his opinion upon the chest x-rays, pulmonary function testing, arterial blood gas studies, and the physical examinations of record. Dr. Castle related the Miner's chronic bronchitis and chronic obstructive pulmonary disease to smoking. He stated that the Miner's shortness of breath was most likely related to coronary artery disease. Dr. Castle found the Miner totally disabled as a result of severe coronary artery disease and lung cancer. (EX 4).

The record also includes a June 20, 2000, medical report from Thomas M. Jarboe, M.D., Board-certified in Internal Medicine and Pulmonary Diseases. (DX 63). Dr. Jarboe noted a 32-year coal mine employment history as a loader operator, roof bolter, cutting machine operator, joy loader, and a hand loader. Dr. Jarboe summarized the medical reports and testing that he

reviewed. Dr. Jarboe opined that the Miner did not suffer from pneumoconiosis. He based his opinion on the chest x-ray evidence, the CT scans and the pulmonary function testing. Dr. Jarboe stated that the CT scans revealed irregular scarring in left upper lobe and nodules in the right upper lobe. He noted that these findings are not consistent with pneumoconiosis. He related the Miner's symptoms to smoking and congestive heart failure. Dr. Jarboe also opined that the Miner only suffered from a mild ventilatory impairment based on the pulmonary function testing and arterial blood gas studies that he reviewed. However, he stated that he only had limited data on which to base this opinion. Dr. Jarboe then noted that from a respiratory perspective, the Miner was not totally disabled and could have performed his coal mine employment. Nevertheless, he found the Miner totally disabled based on his severe coronary artery disease. (DX 63).

Dr. Jarboe reiterated his findings and opinions in his July 10, 2000, deposition testimony. (DX 66). He testified that he was in a better position to form an opinion on the Miner's condition than a physician who actually examined the Miner because he was able to review a number of different reports and testing. He agreed that the Miner had sufficient coal dust exposure and smoking histories to have an impact on his respiratory and cardiac systems. However, Dr. Jarboe stated that the Miner's history of coronary artery disease unrelated to coal dust exposure was the most likely cause of his symptoms. He further stated that the pulmonary function testing was within the normal limits, which supports a finding of no pneumoconiosis. He related the Miner's mild airflow obstruction to smoking and possibly heart failure. He based this opinion on the fact that the Miner had no reduction in his FVC or FEV_1 levels. Dr. Jarboe also acknowledged that the Miner's arterial blood gas studies varied at times and, as a result, he related the Miner's condition to coronary artery disease. He continued to opine that the Miner had no respiratory impairment but that he was disabled due to his congestive heart failure. (DX 66).

Dr. Jarboe then submitted a supplemental report on December 14, 2000. (DX 80). He reviewed additional medical evidence in the record. However, he continued to opine that the Miner did not suffer from pneumoconiosis or any other condition related to coal dust exposure. He based his opinion on the CT scan evidence and the negative chest x-ray readings. Dr. Jarboe acknowledged that the Miner suffered from a "significant impairment of gas exchange" based on the testing conducted by Dr. Rasmussen. He related the condition to the Miner's coronary artery disease based on the CT scan evidence. Dr. Jarboe continued to believe that the Miner was not totally and permanently disabled from a respiratory standpoint. (DX 80).

Dr. Jarboe provided a final supplemental report on January 22, 2006. (DX 7). Dr. Jarboe reviewed the additional medical evidence in the record. He continued to find that the evidence does not support a finding of pneumoconiosis. He based his opinion upon the chest x-rays, CT scans, and pulmonary function testing. Dr. Jarboe stated that the Miner's interstitial lung disease is not characteristic of coal dust exposure. He further continued to find that the Miner's disabling impairment was related to chronic severe congestive heart failure. He also related the impairment to airflow obstruction and emphysema related to smoking. (EX 7).

Lawrence Repsher, M.D., Board-certified in Internal Medicine with a Subspecialty in Pulmonary Diseases, provided a consultative report on June 22, 2000. (DX 63). He recorded a history of 32 years in coal mine employment. Dr. Repsher noted that the Miner worked as a roof bolter and loading coal. The Miner left coal mine employment due to a stroke. Dr. Repsher

stated that he found that the medical records revealed varying smoking histories. He found histories between five to six cigarettes per day for 40 years and as much as two-thirds a pack of cigarettes per day between 1943 and 1996. Dr. Repsher documented the Miner's medical history. He reviewed the chest x-ray readings of the other physicians and the pulmonary function and arterial blood gas studies. Dr. Repsher found that the spirometry revealed chronic obstructive pulmonary disease associated with cigarette smoking. The tests revealed a purely obstructive defect without a response to bronchodilators. He explained that when a person suffers from pneumoconiosis, he/she will experience a restrictive defect. Dr. Repsher attributed the Miner's reduced arterial blood gases to his coronary artery disease and smoking history. Therefore, Dr. Repsher found no evidence of pneumoconiosis based on the chest x-ray evidence and pulmonary function testing. However, Dr. Repsher opined that the Miner was totally and permanently disabled and would have been unable to perform his regular coal mine employment. He related the disability solely to severe coronary artery disease unrelated to coal dust exposure. (DX 63).

Dr. Repsher provided a supplemental report on December 19, 2000. (DX 81). He reviewed additional medical evidence in the record. He discounted the chest x-ray readings of Drs. Ahmed and Cappiello, stating that they always read chest x-rays positive for pneumoconiosis, and he credited the opinions of Drs. Scott, Wheeler, and Wiot, who read the same films as negative. However, he stated no other basis for this inconsistency. Based upon Dr. Rasmussen's pulmonary function testing, Dr. Repsher opined that the Miner suffered from a severe pulmonary impairment. He related the condition to smoking instead of coal dust exposure. Dr. Repsher also diagnosed the Miner with chronic obstructive pulmonary disease and emphysema related to smoking. He disagreed completely with Dr. Rasmussen by stating that the B readers found no evidence of pneumoconiosis. Dr. Repsher also continues to relate the Miner's conditions to coronary artery disease. (DX 81).

Dr. Repsher reiterated the findings in his reports in his December 28, 2000, deposition testimony. (DX 84). He further opined that the Miner did not suffer from pneumoconiosis or any other coal dust-related condition. He related his respiratory impairment solely to smoking and coronary artery disease. He based his opinion on the objective testing within the record. (DX 84).

Dr. Repsher submitted another supplemental report dated January 5, 2006. (EX 1). He again reiterated his opinions in his prior reports. He continued to find that the Miner did not suffer from pneumoconiosis. He found him only totally disabled due to his coronary artery disease. Dr. Repsher also discussed Dr. Mavi's findings of chronic obstructive pulmonary disease related to coal dust exposure. Dr. Repsher agreed that the Miner suffered from chronic obstructive pulmonary disease but he related the condition solely to cigarette smoking and found that the condition was "of no clinical significance." He based his opinion on the pulmonary function testing. (EX 1).

D.L. Rasmussen, M.D., Board-certified in Internal and Forensic Medicine, examined the Miner on May 31, 2000. (DX 65). Dr. Rasmussen submitted a report discussing his findings upon examination and review of the other medical evidence in the record. He noted that the Miner had a history of progressive shortness of breath (20 years), chronic productive cough, wheezing, occasional paroxysmal nocturnal dyspnea, and coronary artery disease. He stated that the Miner smoked half a pack of cigarettes between 1942 and 1995. The Miner worked 25 years

in coal mine employment. Upon examination, Dr. Rasmussen noted a normal chest expansion, reduced breath sounds, bilateral basilar rales and prolonged expiratory phases with forced respirations. He also performed a chest x-ray, pulmonary function tests, and an arterial blood gas study. Dr. Rasmussen diagnosed the Miner with pneumoconiosis based on his history of coal dust exposure and a positive x-ray reading. He also found the Miner totally disabled from a respiratory standpoint based on the arterial blood gas studies, which disability he related to coal dust exposure. Although Dr. Rasmussen stated that smoking was partially to blame for the Miner's impairment, he noted that the pattern of the Miner's impairment was not typical of smoking-induced chronic lung disease. Furthermore, Dr. Rasmussen stated that the Miner's congestive heart failure was not responsible for his loss of lung function and diffusing capacity. He cited medical research to support his opinion.[5] (DX 65).

The Claimant submitted a supplemental report from Dr. Rasmussen written on January 15, 2001, after he reviewed additional medical evidence. (DX 89). He disagreed with the medical opinions of Drs. Branscomb, Dahhan, Morgan, Fino, and Jarboe, stating that they should not have excluded coal dust exposure from their causes of the Miner's conditions. He stated that the Miner's respiratory function has been abnormal for many years even if it has not declined. Also he opined that obesity is not the cause of the Miner's problems. Dr. Rasmussen stated that "obese individuals generally improve their oxygenation of exercise and it is noteworthy that two minutes following the exercise, while [the Miner] remained standing on the treadmill, his PA02 had actually increased to 77, PACO2 of 35. He was certainly no less obese standing on the treadmill post exercise as during exercise." Dr. Rasmussen discounted Dr. Morgan's opinion by stating that he took into consideration irrelevant medical research studies which are distinguishable from the Miner's situation. He also disagreed with Drs. Dahhan and Jarboe that the Miner's impaired oxygen transfer was due to coronary artery disease. The Miner's anaerobic threshold was normal. He opined that "were [the Miner] to have had significant cardiac limitations, he would have exceeded his anaerobic threshold permanently." Dr. Rasmussen stated that none of the studies revealed hypoxia during exercise. Therefore, he continued to opine that the Miner suffered from pneumoconiosis and was impaired by the condition. (DX 89).

Dr. Rasmussen then wrote another supplemental report on January 16, 2001, after reviewing the medical reports of Drs. Castle, McSharry, and Repsher. (DX 89). He disagreed with their opinions that the Miner's hypoxia was related to his cardiac condition. He adopted the same reasoning as in his January 15, 2001, report. He also cited numerous research studies to support his opinion. (DX 89).

Roger J. McSharry, M.D., Board-certified in Internal Medicine, Pulmonary Diseases, and Critical Care Medicine, submitted a consultative report written July 3, 2000. (DX 68). Dr. McSharry summarized all the records that he reviewed. He noted that the Miner worked 32 years in coal mine employment. He noted a history of obesity, chronic bronchitis, coronary artery disease, cardiac vascular disease, a cerebral vascular accident, and smoking. Dr. McSharry related the Miner's shortness of breath to "cardiac dysfunction, obesity, deconditioning, and anemia as well as pulmonary causes." He diagnosed the Miner with a possible mild airflow obstruction based on the pulmonary function testing. However, he

[5] Dr. Rasmussen also submitted a letter dated June 26, 2000, which discussed the findings from his May 31, 2000, examination and his review of the other medical records. (DX 89).

acknowledged that the testing was invalid and normal at times. Dr. McSharry found that the chest x-ray evidence did not support a finding of pneumoconiosis based upon the readings of the other physicians. He gave the interpretations of Dr. Wiot the greatest weight. He also found evidence of hypoxemia based on the arterial blood gas studies but he related the condition to obesity, atelectasis, congestive heart failure, and chronic bronchitis. However, he never actually explained how he determined that coal dust exposure did not cause, in part, the hypoxemia. (DX 68).

Dr. McSharry ruled out pneumoconiosis by stating that it would have shown up on the chest x-ray data and would have affected the Miner's pulmonary function testing. (DX 68). "Symptomatic coal worker's pneumoconiosis would be expected to cause significant derangement in pulmonary function tests. These abnormalities are not seen in this case." Dr. McSharry further found that the Miner did not suffer from a respiratory impairment "of significance." He opined that the Miner could have performed his regular coal mine employment from a respiratory perspective. He based his opinion upon the pulmonary function testing. Dr. McSharry related the minor abnormalities seen in the pulmonary function testing to chronic bronchitis related to smoking. He opined that,

> This condition is caused by cigarette smoking however and is not likely related to coal mining. Industrial bronchitis can certainly cause chronic cough and sputum production, but the fact that [the Miner] has not been exposed to coal or coal dust for the last 22 years makes his ongoing symptoms at this time clearly unrelated to his previous occupation.

Dr. McSharry then explained that the Miner was disabled due to his coronary artery disease unrelated to coal dust exposure. (DX 68).

The record also includes a supplemental report by Dr. McSharry written on December 17, 2000. (DX 81). He continued to opine that the evidence does not suggest a finding of pneumoconiosis. He stated that the lower lobe infiltrates and pleural abnormalities found on the chest x-rays are not typical of pneumoconiosis. The pulmonary function testing revealed an obstructive lung disease which he related to basilar pulmonary infiltrates. He could not state an etiology for the pulmonary infiltrates, but he opined that the Miner's diffusion abnormalities were not related to cigarette smoking because the obstruction was only trivial. Dr. McSharry determined that the Miner's coronary artery disease and anemia were the causes of his hypoxemia. (DX 81).

Dr. McSharry provided another supplemental report on January 16, 2006. (EX 3). He reiterated his findings and opinions in his other reports. Dr. McSharry continued to opine that the Miner did not suffer from pneumoconiosis or any other coal dust-related condition. He based his opinion on the chest x-ray evidence. He related the Miner's lung problems to cancer unrelated to coal dust exposure. Dr. McSharry mentioned that the Miner suffered from chronic obstructive pulmonary disease but he neither related the condition to coal dust exposure nor provided a basis for the opinion. Dr. McSharry never actually stated whether the Miner was actually totally disabled or not. (EX 3).

Andrew J. Ghio, M.D., Board-certified in Internal Medicine with a Subspecialty in Pulmonary Diseases, submitted a consultative report dated January 15, 2006. (EX 5). Dr. Ghio

recorded that the Miner had a medical history of severe heart disease, coronary artery disease, cerebrovascular disease, stroke, gastrointestinal diseases, obesity, breast cancer, and pneumonia. He found that the Miner worked 22-25 years in coal mine employment. The Miner smoked half a pack to 1½ packs of cigarettes per day between the ages of 13 and 68. Dr. Ghio completely summarized all the evidence that he reviewed. He found no evidence of clinical pneumoconiosis. He stated that the Miner's abnormalities that showed up on the chest x-rays were related to smoking and heart failure. Dr. Ghio agreed that the findings suggested that the Miner suffered from chronic obstructive pulmonary disease, which he related to smoking. He found no evidence legal pneumoconiosis based upon the chest x-rays, pulmonary function tests, CT scans, and his medical research. Dr. Ghio also found evidence of lung cancer unrelated to coal dust exposure. He found that the Miner suffers from an obstruction and decreased diffusing capacity, but he stated that the impairment was only mild to moderate and not consistent with pneumoconiosis. However, Dr. Ghio stated that the Miner would not have been able to perform his regular coal mine employment due to his coronary artery disease. (EX 6).

Dr. Ghio further explained his opinions and findings in his February 14, 2006, deposition testimony. (EX 9). He found no evidence of a coal dust-induced medical condition. Dr. Ghio testified that the Miner's coronary artery disease, lung cancer, and chronic obstructive pulmonary disease were not related to coal dust exposure. He based his opinion upon the chest x-rays, CT scans, and pulmonary function testing. (EX 9).

Hospital and Treatment Records

The record includes the Miner's hospital and treatment records throughout the years prior to his death. (CX 1; DX 11, 13, 55A). The records included a number of CT scans, chest x-rays, and a biopsy; however, none of the results revealed a finding of pneumoconiosis or a condition related to pneumoconiosis. The results revealed the Miner's lung cancer, chronic interstitial disease, pleural effusion, subpleural scarring, and emphysematous changes. The interpreters never attributed these conditions to coal dust exposure. The Miner was also consistently diagnosed with breast cancer, lung cancer, hypertension, obesity, GERD, coronary artery disease, emphysema, stroke, and chronic obstructive pulmonary disease. However, the physicians never relate these conditions to coal dust exposure. Also there is a notation diagnosing the Miner with a history of black lung disease and silicosis; however, the records include no basis or explanation for these findings. (CX 1; DX 11, 13, 55A).

DISCUSSION AND APPLICABLE LAW MINER'S CLAIM

Because the Miner filed his application for benefits after March 31, 1980, his claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations, a claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. 20 C.F.R. § 725.202(d)(2)(i-iv). Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989).

Threshold Issue for Subsequent Claims

Under the amended regulations of the Act, the progressive and irreversible nature of pneumoconiosis is acknowledged. 20 C.F.R. § 718.201(c). Consequently, claimants are permitted to offer recent evidence of pneumoconiosis after receiving a denial of benefits. *Id.* The new regulations provide that where a claimant files a subsequent claim more than one year after a prior claim has been finally denied, the subsequent claim must be denied on the grounds of the prior denial unless the "[c]laimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. § 725.309(d). If a claimant establishes the existence of an element previously adjudicated against him, only then must the Administrative Law Judge consider whether all the evidence of record, including evidence submitted with the prior claim, supports a finding of entitlement to benefits. *Id.* A duplicate claim will be denied unless a claimant shows that one of the applicable conditions has changed since the date of the previous denial order. *Id; see also, Sharondale Corp. v. Ross*, 42 F.3d 993, 997-998 (6th Cir. 1994).

Accordingly, because the Miner's previous claim was denied, the Claimant now bears the burden of proof to show that one of the applicable conditions of entitlement has changed. 20 C.F.R. § 725.309(d). I must review the evidence developed and submitted subsequent to May 27, 1997, the date of the prior denial, to determine if the Miner meets this burden. *Id.*

In the prior claim the Miner did not prove any of the elements of entitlement. Therefore, if any of the elements of entitlement are proven in this claim, a material change in condition will have been established. I will then reopen the record and take all the new and old evidence into consideration when formulating my entitlement decisions. 20 C.F.R. § 410.410(b).

Pneumoconiosis and Causation

Section 718.202 provides four means by which pneumoconiosis may be established: chest x-ray, biopsy or autopsy, presumption under §§ 718.304, 718.305, or 718.306, or if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the Miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. § 718.202(a). The regulatory provisions at 20 C.F.R. § 718.201 contain a definition of "pneumoconiosis" provided as follows:

> (a) For the purposes of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition

includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthro-silicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

It is within the Administrative Law Judge's discretion to determine whether a physician's conclusions regarding pneumoconiosis are adequately supported by documentation. *Lucostic v. United States Steel Corp*., 8 B.L.R. 1-46, 1-47 (1985). "An administrative law judge may properly consider objective data offered as documentation and credit those opinions that are adequately supported by such data over those that are not." *See King v. Consolidation Coal Co*., 8 B.L.R. 1-262, 1-265 (1985).

A. X-ray Evidence

Under § 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (*en banc*); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP,* 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

The preponderance of the chest x-rays in the record do not support a finding of pneumoconiosis. Dr. Younes, a B reader, and Dr. Barrett, a B reader and Board-certified Radiologist, found the January 13, 1999, chest x-ray positive for pneumoconiosis; however, Drs. Sargent, Scott, and Wheeler, all Board-certified Radiologists and B readers, found the film completely negative. Dr. Dahhan, a B reader, also found the film negative. Accordingly, based on the preponderance of more highly qualified readings, I find that the January 13, 1999, x-ray does not support a finding of pneumoconiosis.

Next, Dr Ahmed, a B reader and Board-certified Radiologist, found the July 17, 1999, chest x-ray positive for pneumoconiosis; however, Dr. Wiot a B reader and Board-certified Radiologist, found the chest x-ray negative. Therefore, their readings cancel each other out. Drs. Dahhan, Fino, and Morgan, all B readers, also found the film negative, but their readings are outweighed by the reading of Dr. Cappiello, who is a B reader and Board-certified Radiologist. Therefore, I find the July 17, 1999, film positive for pneumoconiosis.[6] Drs. Ahmed and

[6] The record also included a reading by Dr. Barrett dated June 12, 2000; however, the reading had a post-it note attached stating that the reading was misdated and should have read July 17, 1999. (DX 98). The note was unsigned and was not from the actual physician. Therefore, I must treat the interpretation as a reading of the June 12, 2000, film.

Cappiello also read the December 18, 1999, film as positive, while Drs. Fino and Wiot read the film as negative. Therefore, since Dr. Fino is only a B reader and both Drs. Ahmed and Cappiello are Board-certified Radiologists and B readers, I find the film positive for pneumoconiosis.[7]

The record also includes seven readings of the May 31, 2000, chest x-ray. Drs. Patel and Miller, both B readers and Board-certified Radiologists, were the only physicians who found the film positive. One Board-certified Radiologist and four combined B readers and Board-certified Radiologists found the film negative. Therefore, I find the May 31, 2000, chest x-ray negative for pneumoconiosis.

Finally, Dr. Miller, a B reader and Board-certified Radiologist, was the only physician who found the June 12, 2000, chest x-ray positive. One Board-certified Radiologist and four combined B readers and Board-certified Radiologists all found no abnormalities consistent with pneumoconiosis when reading the film. Accordingly, I find the film negative for pneumoconiosis.

The Claimant must prove pneumoconiosis by a preponderance of the evidence. Two of the chest x-rays support a finding of pneumoconiosis, while three do not. Accordingly, I find the Claimant has not established pneumoconiosis under § 781.202(a)(1).

B. Autopsy/Biopsy

Pursuant to § 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. Although there is no autopsy evidence to take into consideration, the Miner's treatment records include a biopsy taken to determine whether the Miner suffered from lung cancer. (CX 1; DX 11, 13, 55A). The results did not discuss whether the Miner suffered from pneumoconiosis or any other coal dust-related condition. Therefore, I find the Claimant has not proven pneumoconiosis under § 718.202(a)(2).

C. Presumptions

Section 718.202(a)(3) provides that it shall be presumed that the Miner is suffering from pneumoconiosis if the presumptions described in §§ 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, § 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

D. Medical Opinions

Section 718.202(a)(4) provides another way for a claimant to prove that he has pneumoconiosis. Under § 718.202(a)(4), a claimant may establish the existence of the disease if

[7] The record includes another reading by Dr. Barrett dated June 12, 2000; however, this reading also had a post-it note attached stating that the reading was misdated and should have read December 18, 1999. (DX 98). The note was unsigned and was not from the actual physician. Therefore, I must treat the interpretation as a reading of the June 12, 2000, film.

a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion might support the presence of the disease if it is supported by adequate rationale, notwithstanding a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 9 B.L.R. 1-22, 1-24 (1986). The weight given to a medical opinion will be in proportion to its well-documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 B.L.R. 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms, and patient's history. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Buffalo v. Director*, OWCP, 6 B.L.R. 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp*., 2 B.L.R. 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (*en banc*).

The physicians' reports are set forth above. Drs. Rasmussen and Younes found that the Miner suffered from clinical pneumoconiosis, Dr. Mavi opined that the Miner suffered from legal pneumoconiosis, and all the other physicians of record found no evidence of pneumoconiosis. However, Dr. Younes opined that the Miner suffered from pneumoconiosis based solely upon the readings of a chest x-ray and the Miner's history of dust exposure. (DX 7). In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute sound medical judgment under § 718.202(a)(4). *Id.* at 576. The Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a Miner worked for a certain period of time in the coal mines alone does not tend to establish that he has any respiratory disease arising out of coal mine employment. *Taylor*, 8 B.L.R. at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a Miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray ... and not a reasoned medical opinion." *Id*.

Acknowledging that Dr. Younes performed other physical and objective testing, he listed that he expressly relied on the Miner's positive chest x-ray and coal dust exposure for his clinical determination of pneumoconiosis. (DX 7). Moreover, he failed to state how the results from his other objective testing might have impacted his diagnosis of pneumoconiosis. As Dr. Younes does not indicate any other reasons for his diagnosis of clinical pneumoconiosis beyond the chest x-ray and exposure history, I find his report with respect to a diagnosis of clinical pneumoconiosis is unreasoned and I afford it little weight. Dr. Younes did not diagnose the Miner with legal pneumoconiosis. He related the Miner's chronic bronchitis and chronic

obstructive pulmonary disease to smoking and his hypoxemia to congestive heart failure. (DX 7).

In Dr. Rasmussen's first report he states that he relies upon the Miner's chest x-ray and coal dust exposure for his diagnosis of pneumoconiosis. (DX 65). However, in his supplemental reports he explained that he also relied upon the Miner's other clinical testing and symptoms. (DX 89). Therefore, I find his overall clinical pneumoconiosis opinion well reasoned and well documented.

Drs. Dahhan, Branscomb, Fino, Castle, Jarboe, Repsher, McSharry, and Ghio all found that the Miner did not suffer from clinical pneumoconiosis based upon the preponderance of the negative chest x-rays, pulmonary function testing, and the CT scans. All their opinions are well reasoned and supported by the probative evidence in the record. Dr. Morgan also found no evidence of pneumoconiosis; however, he based part of his opinion on his belief that pneumoconiosis does not progress after exposure has ceased. This proposition is not in accord with the prevailing view of the medical community, the substantial weight of the medical evidence, the scientific literature or the regulations all opining that pneumoconiosis is a progressive disease. Therefore, I accord less weight to Dr. Morgan's opinion.

Therefore, based upon the preponderance of the negative chest x-ray readings and the preponderance of the well-reasoned medical opinion reports finding no clinical pneumoconiosis, I find that the Clamant has failed to prove clinical pneumoconiosis under § 718.202(a).

Next, Dr. Mavi diagnosed the Miner with legal pneumoconiosis. (DX 28; CX 2). He opined that the Miner suffered from chronic obstructive pulmonary disease and diffuse interstitial lung disease, both related to coal dust exposure. He based his opinion upon the Miner's chest x-rays, pulmonary function tests, the progressive nature of the Miner's condition, and his treatment of the Miner throughout the years. I find his opinion well reasoned and well documented on the issue of legal pneumoconiosis. Dr. Mavi made no clinical pneumoconiosis findings.

Drs. Dahhan, Fino, Branscomb, Castle, Jarboe, Repsher, McSharry, and Ghio all found that the Miner did not suffer from legal pneumoconiosis. They related the Miner's respiratory conditions to smoking, coronary artery disease, and obesity. They based their opinions upon the objective medical data in the record. I find all their opinions well reasoned and well documented.

Therefore, based upon the preponderance of the well-reasoned medical opinion reports finding no evidence of legal pneumoconiosis, I find that the Claimant has failed to prove legal pneumoconiosis by a preponderance of the evidence under § 718.202(a).

Causation of Pneumoconiosis

Once it is determined that a claimant suffers from pneumoconiosis, it must be determined whether the claimant's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). The burden is upon the Claimant to demonstrate by a preponderance of the evidence that the Miner's pneumoconiosis arose out of his coal mine employment. 20 C.F.R. § 718.203(b) provides:

> If a Miner who is suffering or has suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arouse out of such employment.

Id.

Since I have found that the Claimant failed to prove that the Miner had pneumoconiosis, the issue of whether pneumoconiosis arose out of the Miner's employment in the coal mines is moot.

Total Disability Due to Pneumoconiosis

The Miner in this claim is deceased. He died on November 13, 2001. Since he has failed to prove pneumoconiosis, he is unable to succeed in his claim for benefits. Therefore, I find that he is not entitled to benefits. Since the Miner is deceased and he can no longer experience a change in condition, I will not discuss whether he has proven totally disabled.[8] Furthermore, since I found that he has failed to prove pneumoconiosis, the issue of total disability due to pneumoconiosis is moot.

ENTITLEMENT

This claim involved a living miner's claim and a survivor's claim. The Claimant has not established the presence of pneumoconiosis, that such pneumoconiosis arose out of coal mine employment, or that the Miner was totally disabled due to pneumoconiosis in the Miner's claim. Therefore, the living Miner's claim for benefits under the Act shall be denied. However, since the undersigned dismissed the responsible operator in the survivor's claim, her claim is no longer contested. Therefore, the Claimant's claim for survivor's benefits under the Act shall be granted.

Attorney's Fees

The award of attorney's fees, under this Act, is permitted only in cases in which the Claimant is found to be entitled to the receipt of benefits. Therefore, Claimant's attorney is only entitled to attorney fees for the work he performed on the survivor's claim. However, no award of attorney's fees for service to the Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for Claimant's counsel to submit an application. *Bankes v. Director*, 8 BLR 2-1 (1985). The application must conform to 20 C.F.R. §§ 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including the Claimant and the Solicitor, as counsel for the Director. Parties so served shall have 10 days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge the Claimant any fee in the absence of the approval of such application.

[8] Even if the Miner had proven total disability and thereby established a material change in condition, he would not have been successful in this claim. After taking into consideration the old evidence with the new, I would have continued to find that the preponderance of the evidence does not support a finding of pneumoconiosis. Therefore, this claim cannot be successful in his claim for benefits.

ORDER

It is HEREBY ORDERED that:

1. The living miner's claim of G.B., for the Estate of J.B., for benefits under the Black Lung Benefits Act is hereby DENIED;

2. The claim for survivor's benefits of G.B. under the Act is hereby GRANTED;

3. The Black Lung Trust Fund shall pay G.B. all benefits to which she is entitled under the Act, beginning November 2001; and,

4. The Black Lung Trust Fund shall pay the Claimant's attorney fees and expenses to be established in a supplemental decision and order.

A

JOSEPH E. KANE
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the Administrative Law Judge's Decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the Administrative Law Judge's Decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC, 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* C.F.R § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's Decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).